STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175517	A. BUILDING _____ B. WING _____	C 10/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWEET LIFE AT BROOKDALE PLACE	12000 LAMAR OVERLAND PARK, KS 66209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The follow citations represent the findings of Complaint Investigation #60333.	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 93 residents and the sample included 3 residents. Based on observation, record review, and staff interviews, the facility failed to access and provide supervision for 1 resident (#1) of the sample to prevent the resident from leaving the facility unsupervised. Findings included: - Resident #1's admission Minimum Data Set (MDS) 3.0 dated 8/29/12 recorded a Brief Interview for Mental Status score of 6 (severely impaired); required limited assistance of one staff with bed mobility, walking in room/corridor, locomotion on unit, and personal hygiene; extensive assistance of one staff with transfers, dressing, and toilet use; supervision of one staff assist with eating; had no wandering behavior; and utilized a walker.	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1	F 323		

The Care Area Assessment (CAA) dated 8/31/12 for cognitive loss/dementia recorded the resident had a diagnosis of dementia (memory impairment). He/she exhibited short-term memory loss, impulsivity, and poor decision-making ability. He/she frequently got up without assistance, and the staff frequently reminded him/her about the importance of waiting for staff to assist him/her. The resident was recently admitted to the hospital with a urinary tract infection (UTI) and had just completed a course of antibiotic therapy. The resident would be referred to social services.

The care plan last reviewed 8/31/12 indicated the resident had some problems with cognition, such as short-term memory and decision making skills. The resident had the diagnosis of dementia which could affect his/her cognition. The nursing intervention included the resident may need some cueing and prompting to complete some of his/her Activities of Daily Living (ADL) and the staff monitored the resident for safety. A care plan revision dated 9/12/12 documented "at approximately 4:30 P.M. resident found in parking lot of community and brought back inside with interventions which included resident assessed for injury, resident put on 15 minute checks, the family and physician were notified and the resident was discharged the following day to a secure community".

Review of a history and physical dated 8/19/12 revealed the resident was started on Rocephin (an antibiotic) for a urinary tract infection. The physician spoke to the resident's family member whom agreed the resident was not safe to live independently at this time; however, the resident

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F 323	Continued From page 2	F 323		

had declined any further interventions in the past. Case workers would need to become involved, and "hopefully we can get him/her into a skilled nursing facility and he/she would likely need nursing home placement following that."

Review of the Admission Evaluation Data dated 8/22/12 indicated cognition issues due to mental function varied, the resident had memory problems, and was oriented to person only.

A Social Service Progress Note dated 8/29/12 recorded prior to the resident's hospitalization, the resident had lived independently with a family member at home. The family member was the primary caregiver with hospital notes indicating this was not an ideal living situation for the resident though interventions had yet to be successful. The resident wanted to return home and seemed fairly determined to do so.

An observation during the initial tour on 10/17/12 at 1:30 P.M. , the northeast exit door on Piedmont unit opened without an alarm to an outside sidewalk to the community parking lot.

An interview on 10/17/12 at 1:50 P.M. with maintenance staff X reported all outside exit doors were checked for functioning every Monday and the door alarm had activated on Monday when it was checked. Further observation revealed someone had disalarmed the door alarm.

An interview on 10/17/12 at 4:00 P.M. with administrative nursing staff D revealed the residents were signed out at the nursing station and this information was not relayed to the

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F 323	Continued From page 3 reception desk. An interview on 10/18/12 at 10:30 A.M. with administrative staff B reported he/she had observed resident #1 leave the facility on 9/12/12 at approximately 4:00 P.M. with a group of people, he/she was unaware if the resident had been signed out at the nursing station. He/she reported that he/she did not inquire if the group of people were the resident's family or if the resident had been signed out. An interview on 10/18/12 at 10:58 A.M. with therapy staff EE reported the resident was in no apparent distress when he/she found the resident in the parking lot of the community on 9/12/12 at approximately 4:30 P.M. The resident just appeared confused and was wandering around with his/her walker. The facility failed to provide supervision for this cognitively impaired resident with a desire to leave the facility from leaving the facility unsupervised.	F 323		